MONTANA
TEACHERS' RETIREMENT SYSTEM

1500 E 6TH AVE
PO BOX 200139
HELENA MT 59620-0139
(406) 444-3134

TRS Office Use Only

MONTANA STATE WITHHOLDING CERTIFICATE

(PLEASE TYPE OR PRINT LEGIBLY IN DARK INK.)

Benefit Recipient's Information:

_____ _____-_____-_____ ☐☐☐ ☐☐ ☐☐☐☐
(Name) (Date of Birth) (Social Security Number)

_____
(Home Mailing Address) (City, State & Zip Code)

(_____)_____-_____
(Area Code & Telephone Number)

The method that you elect to utilize in paying your Montana State income tax liability is strictly a personal decision. While the Teachers' Retirement System (TRS) tries to assist you in any way possible, we are not qualified to make decisions for you. We recommend you contact the Montana Department of Revenue, at (406) 444-6900, or a qualified tax professional for advice. Remember, there may be penalties for not paying enough tax during the year, either through withholding or estimated tax payments.

The number of state withholding allowances you claim may be different from the number of allowances you claim for federal withholding.

The election you make and submit on this form will take effect within 60 days after the form is received by the TRS. Your tax withholding preference will remain in effect until you change or cancel your preference. A change or cancellation may be made at any time by completing and submitting to the TRS a new Montana State Withholding Certificate.

****As a reminder, monthly pension benefits are mailed or deposited on the last business day of each month****

Check **only** one line below:

1. {____} Check here if you **do not want any** Montana State income tax withheld from your monthly pension benefit. (Do not complete line 2 or 3.)

2. {____} Total number of allowances **and** marital status you are claiming for withholding from each monthly pension benefit. (You may also designate an additional dollar amount to be withheld).

   Enter Number of allowances: _____

   Enter Marital status: { } Married { } Single { } Married, but withhold at higher "Single" rate

   Additional amount, if any, you want withheld from each monthly pension benefit. $_____

3. {____} I wish to have $_____ withheld from each monthly pension benefit.

_____ _____
(Signature of Benefit Recipient) **(Date)**

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1992,
ALTERNATIVE ACCESSIBLE FORMATS OF THIS DOCUMENT WILL BE PROVIDED UPON REQUEST